Los Angeles County Department of Mental Health
Local Mental Health Plan
REQUEST FOR CHANGE OF PROVIDER
CONFIDENTIAL

To request a change in your current provider, complete **Sections 1 and 2** of this form and submit it to the Program Manager's office. Every effort will be made to accommodate your request. You will receive a notice of the decision within ten (10) business days. If you are a Medi-Cal beneficiary seeing a private provider in the community who is not part of a County program, operated or contracted, call the Beneficiary Services Program in the Patients' Rights Office at 800-700-9996 or 213-738-2524. The Mental Health Plan cannot guarantee that your provider will be changed. If you do not receive a notice of the decision on your request after ten (10) business days or disagree with the decision, you may file a formal grievance.

SECTION 1: CURRENT PROVIDER INFORMATION

Date: _____ Service Location: _____

Provider Name: _____

SECTION 2 : BENEFICIARY / CLIENT INFORMATION

Client Name: _____ Birth Date: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Phone: _____ Are you receiving **Medi-Cal**? ☐ Yes ☐ No

1. I am requesting a change in: ☐ Service Staff ☐ Medical Staff ☐ Program

2. Please select the reason(s) for requesting a change: (OPTIONAL)

☐ A = Appointment Scheduling
☐ B = Language
☐ C = Age (too old / too young)
☐ D = Gender (male / female)
☐ E = Treating family member
☐ F = Treatment concerns
☐ G = Medication concerns
☐ H = Lack of assistance
☐ I = Prefer previous provider
☐ J = Prefer 2nd opinion
☐ K = Uncomfortable
☐ L = Insensitive / Unsympathetic
☐ M = Unprofessional
☐ N = Does not understand me
☐ O = Incompatible
☐ P = Do not want to give a reason
☐ Q = Other - Please describe the reason(s):

_____

3. Have you discussed your concerns with your current provider? ☐ Yes ☐ No

If Yes, please describe what you have done to try to resolve the problem:

_____

I understand that I will be contacted about this request within ten (10) working days. I prefer to be contacted by:
☐ Mail ☐ Telephone ☐ Email: _____

If this request is on behalf of a minor or dependent adult, you are the ☐ Parent ☐ Guardian

Signature of Person making request: _____ Today's Date: _____

SECTION 3: RECEIPT OF CHANGE OF PROVIDER REQUEST

Received By: _____ Date: _____ Copy given to Client: ☐ Yes ☐ No

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SECTION 4: **AUTHORIZED COUNTY USE ONLY**

DSM-IV

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Medications - Specify dosage and frequency:

Reviewed By: _____ Date: _____

Recommendation:

Referral To: _____

Notified: _____ Date: _____

Appointment: _____

Beneficiary / Client Contacted on: _____ By: _____

This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code, and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by Law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____
IBHIS / IS #: _____
Facility / Practitioner: _____

Protected Health Information (PHI)
Los Angeles County Department of Mental Health